

FIG. 1

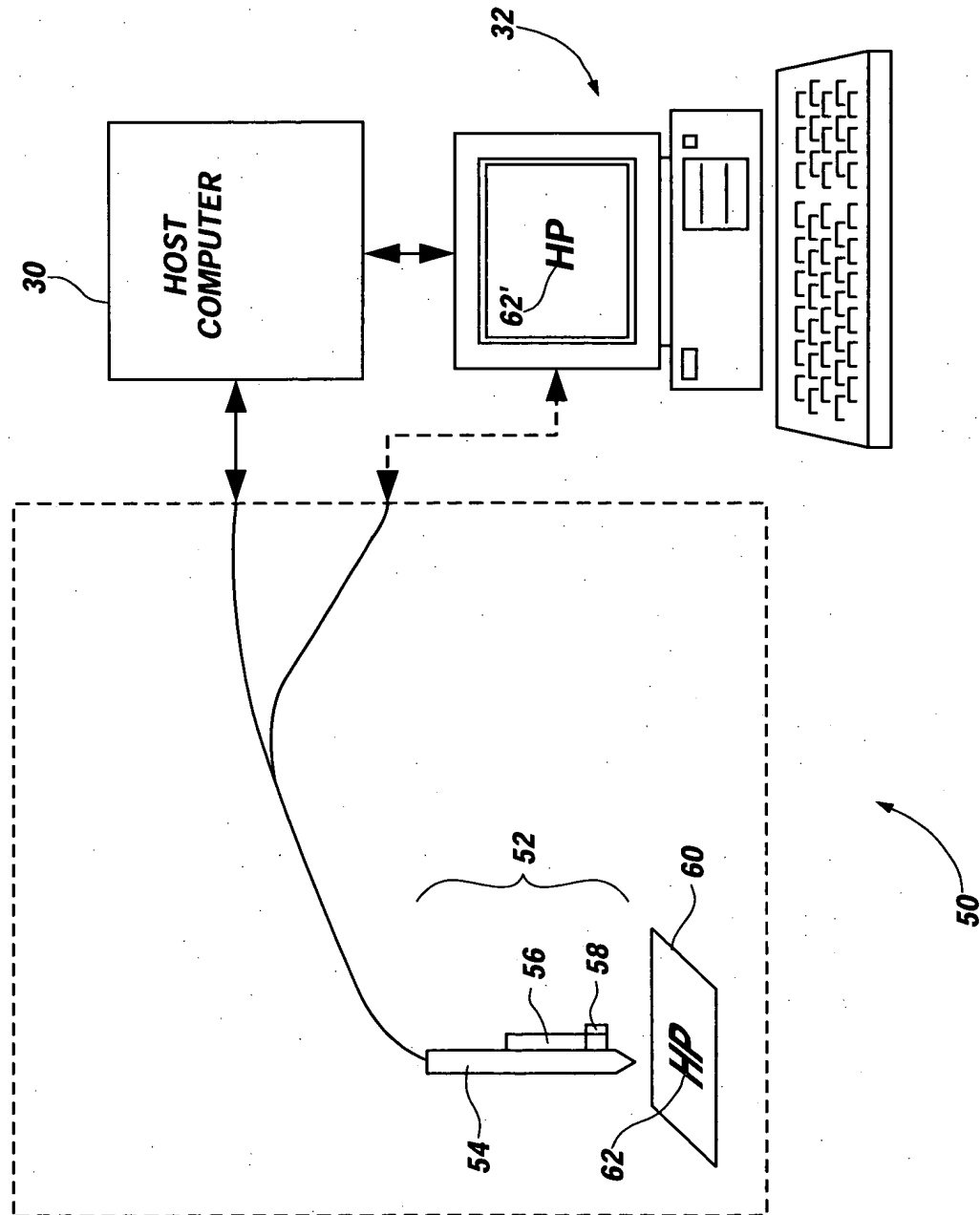


FIG. 2

**VEHICLE INSPECTION REPORT**

Claim Number: 15486650005  
Owner: Mrs Elizabeth Jones  
Date of Loss: 07-10-02  
Date Reported: 07-10-02

Location Address: [Blank]  
Phone Number: [Blank]

Cause of Loss: ☐ Collision ☐ Theft ☐ Road ☐ Vandalism ☐ Fire ☐ Other

**VEHICLE DESCRIPTION**

Year: [Blank] Make: [Blank] Model: [Blank] Series: [Blank] Body Style: [Blank] License Plate Number: [Blank] Expiration Date: [Blank] State: [Blank]

VIN: [Blank] Color: [Blank] Exterior: [Blank] Interior: [Blank]

Engine Type: [Blank] No. Cyl: [Blank] ☐ Gas ☐ Diesel ☐ Turbo ☐ Trans: ☐ Auto ☐ STD ☐ 4 WD

Make: [Blank] Year: [Blank] Mileage: [Blank]

**EQUIPMENT/ACCESSORIES**

SEATS: ☐ Buckle ☐ Power ☐ Leather ☐ Telescoping

STEERING: ☐ Power ☐ 4 Wheel Disc ☐ Add

BRAKES: ☐ Power ☐ 4 Wheel Disc ☐ Add

ROOF: ☐ Vinyl ☐ Sun ☐ T-Top ☐ Convertible

GLASS: ☐ Tinted ☐ Shaded ☐ Heated ☐ Head-Up Display

WHEELS: ☐ Standard ☐ Alum/Mag Alloy ☐ Chrome ☐ Wire

RADIO: ☐ OEM ☐ Non-OEM Brand ☐ AM/FM Stereo ☐ Tape Deck ☐ Antenna ☐ Equalizer ☐ CD Player ☐ Power Windows

CELLULAR PHONE: ☐ OEM ☐ Non-OEM Brand

**OTHER INTERIOR**

☐ Power Locks ☐ Cruise Control ☐ Power Mirrors ☐ Shop Bumper ☐ Wrench ☐ Air Fuel T

☐ Thru Receiver ☐ 1994 ☐ New OEM ☐ Ground Effects ☐ Adm Rear Window ☐ Tool Box ☐ Fog Lights

☐ A/C ☐ Air Bag ☐ Longhorn Rack ☐ Sonar/Sonic ☐ Bed Liner ☐ Trailer Tow

☐ Rear A/C ☐ Onco ☐ Res ☐ Spare ☐ Soft Top ☐ Hard Top ☐ Roll Bar ☐ Pig

☐ Digital Dash ☐ Third Seat ☐ Trailer Hitch ☐ Running Board ☐ Light Bar ☐ Light Bar

☐ Camper Shell

**MECHANICAL**

Engine: [Blank] Transmission: [Blank]

**OVERALL CONDITION**

☐ No ☐ Above Avg ☐ Avg ☐ Below Avg

**Prior Damage**

☐ Yes ☐ No Amount \$ [Blank]

Use this space to explain or describe Equipment/Accessories listed above and/or list and describe additional Equipment/Accessories. Estimate Amount: [Blank]

INSPECTED BY: [Blank] DATE: [Blank]

printed using HP laserjet technology

FIG. 3A

Claim Number

Owner Mrs E

Insured

Location Address

FIG. 3B

TE

t/Accessories.

FIG. 3C

Section B Applicant's Medical History											
<p>- Section B is to be completed in the presence of the Medical Examiner and by all applicants unless otherwise stated. - Where not applicable please place N/A next to the question. - If space is not enough please attach an additional sheet of paper and have this signed by the Medical Examiner.</p>											
<b>B-1</b>	<p>Have you started a doctor in the last three years? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Have you ever received hospital treatment or been hospitalized for any reason? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Have you ever undergone or been advised to have surgery? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Are you taking any pills, medicines or having other treatments? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Do you have any physical/mental/communication/developmental/intellectual disabilities which may affect your ability to earn a living or take full care of yourself? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Do you receive a sickness benefit, a pension or any other welfare benefit for medical reasons? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, please provide details:</p> <table border="1"><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr></table>										
<b>B-2</b>	<p>Personal habits of applicant (if over 12 years old):</p> <p>Do you drink alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Do you smoke? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Have you ever smoked? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Do you have any history of dependence on alcohol or other substances (e.g. amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, anxiolytics, sedative-hypnotics)? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, please provide details:</p> <table border="1"><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr></table>										
<b>B-3</b>	<p>Are you suffering from, or have you ever suffered from any of the following:</p> <p>6a Tuberculosis (or have you had contact with a person who has had tuberculosis)? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>6b Leprosy? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>6c Venereal disease (sexually transmitted disease) - specify: <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, please provide details:</p> <table border="1"><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr></table>										

FIG. 4

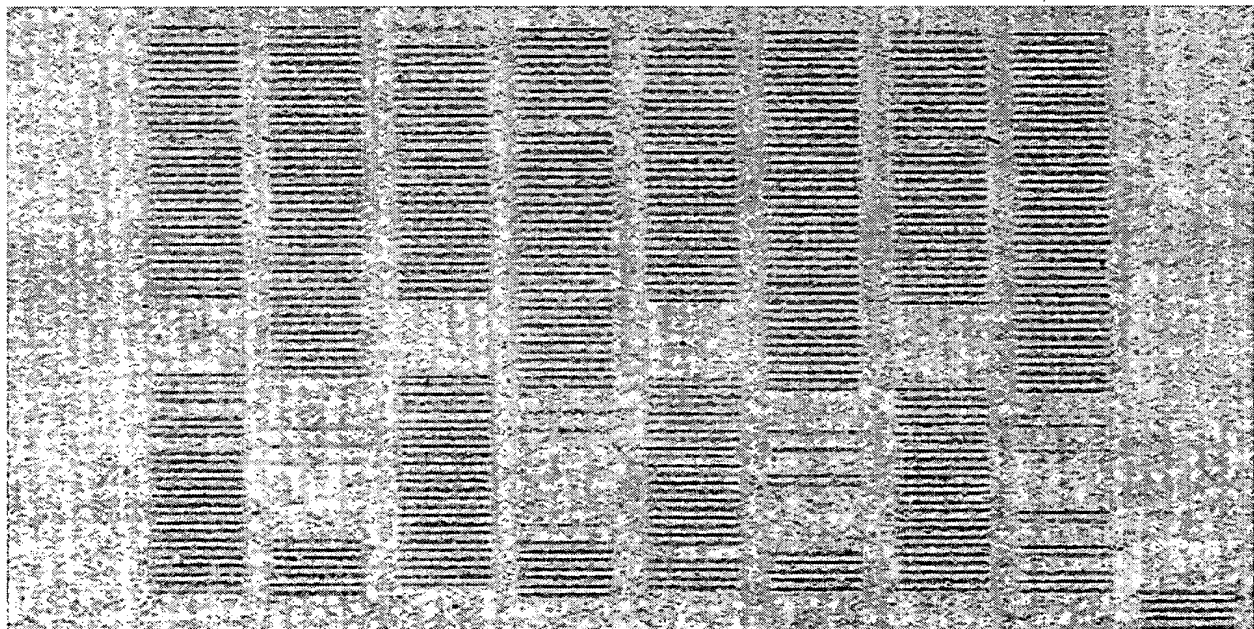
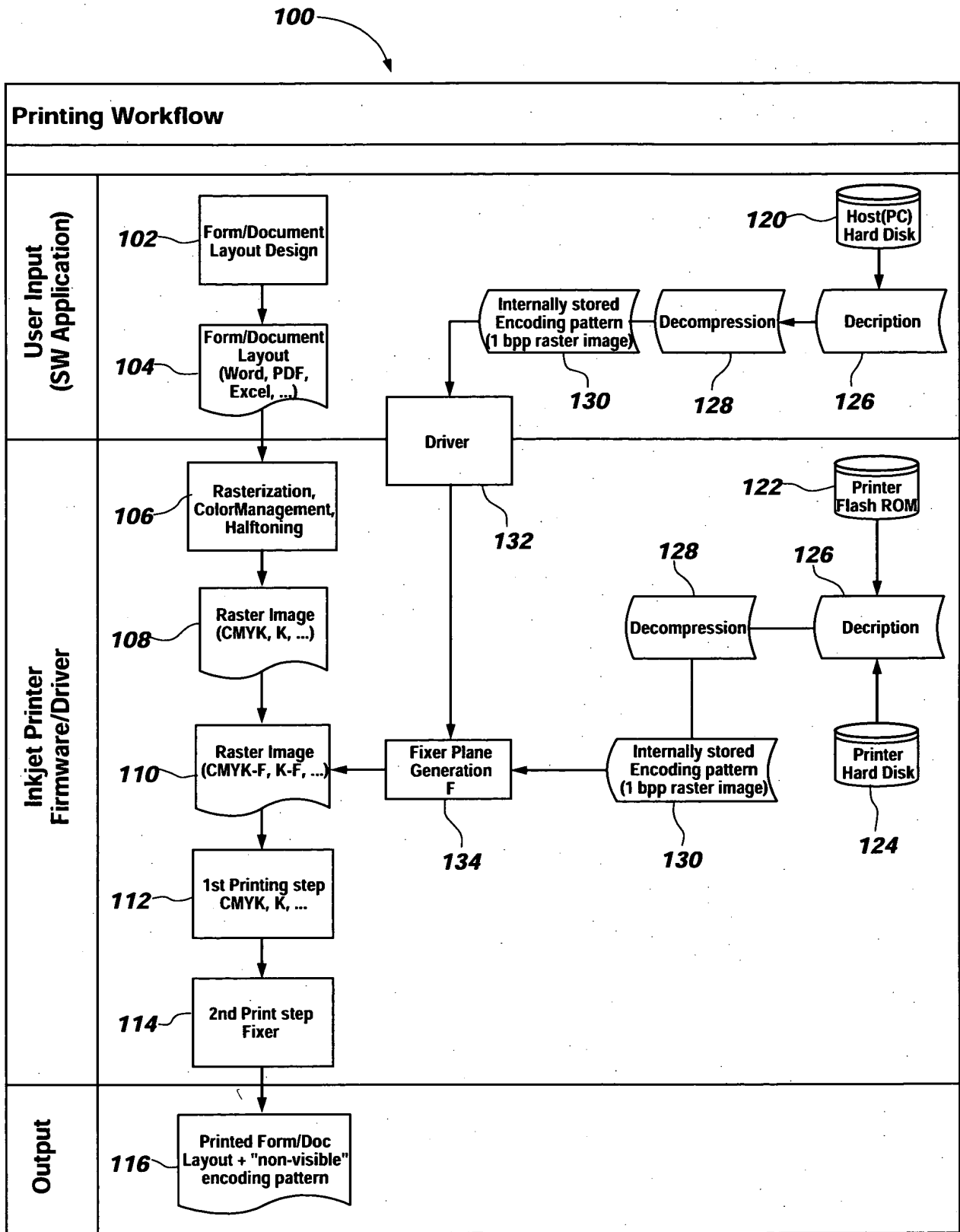


FIG. 5



**FIG. 6**